WILSON PSYCHOLOGICAL ASSOCIATES, PLLC
501 SE Johnstone Avenue, Suite 503
Bartlesville, Oklahoma 74003-6638
(918) 337-6050 Phone
(918) 337-6061 Fax

Psychotherapy and Psychological Assessment Information, Disclosure, and Contract

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you may have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

While the detail included in this document may seem tedious, I believe it is important that you understand from the beginning how situations will be handled in the typical work encountered in my practice. I believe you have the right to know the parameters of our relationship at the outset of our work together. *Please initial each page* and *sign the final page* if you are in agreement with the terms presented.

PSYCHOLOGICAL SERVICES - PSYCHOTHERAPY

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be the most successful, you will have to work on issues we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, psychotherapy has also been shown to have benefits for those who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to set up a meeting with another mental health professional for a second opinion.

My approach to therapy is called Cognitive behavioral therapy (CBT). This is a philosophy of psychotherapy characterized as structured, practical and effective in treating a number of psychological

problems encountered in the course of living. This type of therapy is a strong tool that works by identifying and addressing the behaviors and thinking patterns that maintain the problem or problems you are facing and focuses on your here-and-now thoughts and actions. We will look at how actions, or lack of actions, contribute to whether you feel bad or good. We will also look at the negative and unrealistic ways of thinking that may make you feel depressed, anxious, or uncomfortable. Cognitive behavioral therapy can equip you with the tools to think more realistically, to grow and to live and feel better. At times, there are problems we may work through together, examining both the potential rewards and consequences of particular courses of action you may take. While the therapy is typically focused on the here-and-now, it is sometimes helpful to revisit past experiences from which you may have learned lessons about living that may now out-live their usefulness. While traditional therapy focuses on insight and self-knowledge, CBT is more oriented to action and change. It is important to note that you will always guide the work through the goals and objectives you have for therapy.

You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I have decided to do what I am doing or that I recommend you do, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and you can request that I refer you to someone else if you decide I am not the right therapist for you. You are free to leave therapy at any time, though my preference, if you decide to terminate therapy with me as your therapist, is for us to have one or two sessions to end our work together.

You normally will be the one who decides when therapy will end, with *four exceptions*. 1) If we have contracted for a specific short-term piece of work, we will finish therapy at the end of that contract. 2) If I am not, in my judgment, able to help you because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. 3) If you miss, without cancelling with appropriate notice, three scheduled sessions, I reserve the right to terminate therapy with you. 4) If you do violence to, threaten (verbally or physically), or harass me, the office staff, my family, or family members of the office staff, or damage or destroy property of any of the above mentioned persons, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but I cannot guarantee they will accept you for treatment.

I do not have social relationships with clients or former clients because that would not only be unethical and illegal, it would be an abuse of the power that I have as a therapist. If you have questions about this policy, please bring them with you to your session so we may discuss them.

PSYCHOLOGICAL SERVICES – PSYCHOLOGICAL ASSESSMENT

At times, I may feel that psychological assessment is necessary to assist me in understanding your problem and to facilitate treatment; consequently, I may recommend another provider or I conduct this type of evaluation. Or, you may have been referred for psychological assessment by other professionals (e.g., physicians, teachers, counselors, or attorneys). Psychological assessment typically consists of a diagnostic interview and various objective and projective instruments measuring characteristics such as

intelligence, memory, attention/concentration, personality, neuropsychological status, and/or psychological/emotional symptoms.

In cases where an assessment seems warranted, I will explain what measures I intend to use and the estimated time and cost involved. If you agree, we will proceed with the assessment. Upon completion of the assessment, I will provide you with feedback covering the findings of the evaluation and my interpretation of those findings. I will complete a formal written report of the evaluation and it will be filed with your record in my office. If you desire the written report to be sent to a professional third party, you will be asked to provide written consent for the release of the confidential information. Fees for testing are separate from fees for regular visits and vary according to the tests used and the time involved. My time for scoring the instruments, interpreting the results and writing the report is charged at the psychological testing (procedure code 96101) or neuropsychological testing (procedure code 96118) rate. I do not typically provide clients a copy of the written clinical report as information contained therein may be harmful to untrained readers.

MEETINGS

With regard to psychotherapy, I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually recommend that you schedule one 45-minute session (one appointment hour of 45 minutes duration) per week as the schedule allows, although some sessions may be longer or more frequent. As the schedule is done on a first-come, first-served basis, it is important that you make advance preparation with my office manager, Bekah, for scheduling our meetings. I open my schedule for the third succeeding month on the fifteenth of each new month; any new appointments may be scheduled for the third succeeding month beginning that day (e.g., I will open the December schedule on September 15th and you may then schedule any appointments you desire for the month of December; January will be opened on October 15th, and so on). *It is best for you to schedule your time well in advance and cancel if you decide you no longer need to come or have conflicts that arise as the schedule tends to fill up one to two months in advance.* As only you know your schedule, I rely on you to make sure you are scheduled for the frequency of appointments that we agree upon.

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 45 minutes. If you are late, we will end on time and not run over into the next person's session.

Once an appointment hour is scheduled, to avoid a broken appointment fee, I ask you to provide advance notice of your desire to cancel *by 12:00 pm the business day before your scheduled appointment, unless we both agree that you were unable to attend due to circumstances beyond your control*. If it is possible, I will try to find another time to reschedule your appointment. If you do not provide sufficient notice of cancellation, payment for your broken appointment is your responsibility and will not be billed to your insurance company; you will need to pay the broken appointment fee at or before your next session. This cancellation policy applies to meetings scheduled, and to each hour scheduled for psychological assessments. If you break an appointment for reasons that are not situations *beyond your control,* I will require that you have a valid credit card on file with my office for

the duration of your future treatment. If you miss another appointment for reasons not beyond your control, your credit card will automatically be charged the broken appointment fee. If you develop a pattern of missing scheduled appointments, I reserve the right to terminate therapy with you and offer you a list of referrals. This policy pertains to all clients except those covered by *SoonerCare* or Medicaid Insurance due to state limitations on charges to those covered by these programs.

For clients covered by *SoonerCare* or Medicaid through the Oklahoma Health Care Authority, in accordance with state regulations, if a visit is missed without notice, except in emergency situations, you will be asked to ensure that all future visits are cancelled with appropriate notice. If a second visit is missed without notice by the noon deadline the day preceding the appointment, I will assume therapy is no longer a priority and will terminate therapy with you after an appropriate termination session(s), if possible. If you still desire therapy services, a list of referrals will be provided, but I cannot guarantee another therapist will accept you for treatment.

In order to assist you in remembering your scheduled appointments, my office staff makes reminder calls on the day before your appointment at the number you provide and prefer. However, it remains your responsibility to keep track of your appointments and to attend or appropriately cancel the time reserved for you. We do not overbook appointments; therefore, if you reserve an hour, it is yours unless you provide appropriate notification that you no longer desire the time.

Since I schedule my appointments up to three months in advance, there may be times when I must be out of the office unexpectedly, such as in the event of illness, family emergency, or my own healthcare provider appointments. If I must be out of the office at a time you have scheduled, I will let you know at the earliest point possible and will do my best to reschedule your appointment at a time that we both agree upon. Please know, I take my appointments with my clients seriously and do not cancel appointments arbitrarily.

PROFESSIONAL FEES

I have listed a schedule of fees for your information. My hourly fee for the first psychotherapy session is $185 and the fee for each succeeding session is $145. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly charge if I work for periods of time less than one hour. Other services include telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. Phone calls after office hours are considered crisis intervention and are billed at the rate of $270 per 45 minute hour.

With regard to psychological assessment, my 60 minute hourly fee is $190.00. Neuropsychological assessment (such as a dementia evaluation) is charged at the rate of $220.00 per hour. This fee structure includes review of records for assessment purposes, consultations with other persons, scoring, interpretation, and report writing time.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $300.00 per 60 minute hour for preparation, attendance, and participation, which includes time spent traveling and waiting; this includes any psychological evaluation/assessment or other report that may be required for legal proceedings. In addition to any in-office preparation time, other time is calculated as "Door-to-door" time. Additionally, any and all travel expenses must be paid (including, but not limited to: airfare, lodging, mileage, meals, etc) in order for me to participate in these proceedings. *A retainer fee of $3000.00 must be paid prior to my participation in any legal work* and from this account your charges will be deducted as time is used; the balance of this account must be kept at or above $1000.00 during the legal proceedings and until the issue is settled. Any fee not used after the close of the proceeding will be refunded to you. This fee includes any testimony compelled by another party or by you in my role as a treating expert, fact witness, or expert witness.

My fees go up $10.00 every two years, on the odd year. If a fee raise is approaching, I will remind you of this well in advance.

FEE SCHEDULE

Code	**Service Description**	**Fee**
90801	Diagnostic Interview	$185.00
90804	Individual Psychotherapy (20-25 min)	$ 72.50
90806	Individual Psychotherapy (45-50 min)	$145.00
90808	Individual Psychotherapy (75-80 min)	$242.25
90846	Family Psychotherapy (w/o patient present, 45-50 min)	$145.00
90847	Family Psychotherapy (with patient present, 45-50 min)	$145.00
90853	Group Psychotherapy	$ 72.50
90825	Psychological Evaluation of Records (per hour)	$190.00
90822	Environmental Intervention (per hour)	$145.00
90900	Biofeedback (45-50 min)	$145.00
96101	Psychological Assessment (Psychologist)	$190.00
96102	Psychological Testing (Computer)	$190.00
96103	Psychological Testing (Technician)	$190.00
96105	Testing for Aphasia (per hour)	$220.00
96116	Chart Review, Scoring of Instruments (per hour)	$190.00
96118	Neuropsychological Testing (Psychologist)	$220.00
96119	Neuropsychological Testing (Technician)	$220.00
96120	Neuropsychological Testing (Computer)	$220.00
97770	Cognitive Rehabilitation (per hour)	$190.00
90889	Preparation of Report (per hour)	$190.00
99373	Telephone Consultation (per hour)	$190.00
99075	Legal Partic, Deposition, Testimony, Preparation, Att. (per hour)	$300.00
99049	Broken Appointment (per scheduled hour)	$145.00
00000	Crisis Intervention/Critical Incident Stress Debriefing	$270.00
	Premarital Counseling (per hour)	$145.00

_____ Initials

Document Fee for Record Copy: $1.00 first page; $.25 for each additional page.

Estimates of costs for psychological or neuropsychological evaluation will be furnished upon request prior to beginning the evaluation.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have become increasingly more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary for me to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or in some rare cases copies of the entire record. This information will become part of the insurance company's files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they will do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit to the insurance company, if you request it. Your signature on this document authorizes the above mentioned release.

Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless in rare cases this is prohibited by your

insurance company policy and/or their contract with me as a provider. My Practice Manager, Brianna, will assist you with the preauthorization and interpretation of your benefits.

BILLING AND PAYMENTS

You will be expected to pay for each session on the day of your appointment, unless we firmly agree otherwise in advance or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installation plan. However, I cannot barter for my services.

If you are the parent or guardian of a child and you share medical expenses with the child's other parent/guardian, you will be expected to pay the full fee when you bring the child and work out the portions of payment with your co-parent. At each appointment, the person bringing the child will be responsible for the payment of the fee due at each appointment. Our office does not bill portions (e.g., 60/40) to co-parents.

I am not willing to carry a balance on your account unless we have firmly agreed in advance on a structured payment plan. In these rare cases, if you do not fulfill your agreed upon payments as scheduled, I reserve the right to stop the payment plan and require full payment of fees at the time of the appointment. Accounts that are not paid in full within 30 days will be subject to a $25.00 per month rebilling fee for each month the account remains unpaid. I reserve the right to use a collection agency or other legal means for balances that remain delinquent for more than 120 days. The cost of the collection will be included in the balance.

CONTACTING ME

I am often not immediately available by telephone. My office manager, Bekah, is available Monday through Thursday from 8:30 am to 4:30 pm and Friday from 8:30 am to 12:00 pm. The office is closed daily from 12:00 to 1:00 pm for lunch. If Bekah is not immediately available by phone, you may leave a message on the secure voicemail. Bekah will make every effort to return your call within 24 hours of when you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform her of some times when you will be available. If you require a phone consultation with me lasting longer than 5 minutes, Bekah will ask you to schedule time for us to speak by phone. If you are in the midst of a crisis and need to speak to me promptly, please inform Bekah and she will relay that message to me. As email is neither private nor confidential, I will not communicate with you using this medium. I will do everything in my power to safeguard your privacy and information. I also have a secure voicemail on which you may leave any non-emergency messages.

I am away from the office several times per year for vacations. I will tell you well in advance of any lengthy absences and give you the name and phone number of the therapist who will be covering my practice during my absence. If you experience a crisis when I am out of town, or outside my regular office hours (after 5 pm on weekdays or over the weekend), please call my after-hours urgent-care number at **918-397-1930** to reach the on-call therapist. I cannot guarantee I will be the therapist on call

if you need this service, but each therapist is trained and capable of helping you stabilize or helping you rally the resources needed to help you. The on-call therapist will not contact me until the next business day with a note indicating the nature of your call. While I know it will be your preference to speak to me if you have an urgent situation, I cannot be on call every day, all day, and therefore call is rotated among WPA therapists. (Note: These calls are billed as *Crisis Intervention* and may not be covered by your insurance.) As explained, the urgent care service is staffed by therapists associated with my practice, and on a rotating basis. If you utilize this service and you sign this document, you give authorization for the on-call provider to communicate the information to me when I return to the office to assist in your care.

IF, due to technical or other problems your call is not answered within a reasonable amount of time, please call the (1) Community Outreach Psychiatric Emergency Services – Tulsa (COPES) at **(918) 744-4800** to speak with a crisis counselor, or the (2) National Suicide Prevention Hotline at **1-800-273-8255**, or (3) **1-800-784-2433 (1-800-SUICIDE).** It is important for you to understand that, while I make every effort to be available to you in case of a crisis, there are unrelated circumstances (such as poor cell phone reception) that may prevent me from being available to you at the time you need assistance. Consequently, I believe it is important that you have these contingency plans in place if the on-call therapist is not immediately available by phone.

In a life-threatening emergency where you believe that you cannot keep yourself safe, please do not call the office or the answering service; rather, please go to the nearest emergency room and ask for the mental health worker on call, or call "911" and report to them that you have a life-threatening emergency and that you need transport to the nearest emergency room. Once your safety is assured, you may then have me contacted through the answering service.

SOLE PRACTITIONER

While I share office space with other mental health practitioners, I am a sole psychological practitioner. This office is not to be understood as a 'group practice'; each practitioner is solely responsible for his/her professional conduct and practice.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. I keep brief records noting that you have been here, what topics we discussed, your diagnosis, and what interventions happened in each session. You are entitled to receive a copy of your records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I therefore recommend that we review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any time spent in preparing information requests.

MINORS

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they consent to relinquish access to your records. You will find this agreement for minor psychotherapy clients immediately following this document in the packet of information. If they agree, I will provide them only with general information about our work together, unless I feel that there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a written summary of your treatment when it is complete. Before giving them any information, I will discuss this matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss. Adolescent clients will be asked to review and sign an associated adolescent treatment agreement.

Also, due to the nature of the psychotherapy relationship and the need for the therapist's office to be a "safe zone," I require parents of minor children in therapy to sign an assignment of privilege to the minor child. This waiver is attached to this document and signifies your agreement to not access your child's record without his/her permission. Additional information regarding this waiver may be found on the waiver page attached.

PLEASE NOTE: ANY PARENT/GUARDIAN SEEKING SERVICES FOR A MINOR CHILD MUST HAVE:

1) FULL LEGAL CUSTODY (NOT ONLY FULL PHYSICAL CUSTODY; IF DIVORCED OR SEPARATED, COURT ORDERED DOCUMENTATION OF CUSTODY MUST BE PROVIDED PRIOR TO OR AT THE FIRST VISIT)

Or, 2) CO-SIGNATURE FROM ANY OTHER CUSTODIAL PARENT/GUARDIAN IF THERE IS A JOINT CUSTODY ARRANGEMENT.

If parents are divorced and documentation of FULL CUSTODY or JOINT SIGNATURES on all documents are not provided prior to or at the first appointment, the appointment will be cancelled and a broken appointment fee will be charged.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychologist or counselor is protected by law, and I can only release information about our work to others with your written authorizations. *But, there are a few exceptions*.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if s/he determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person or disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another person, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I strive to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together.

We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law we are prohibited from revealing when we have disclosed this information to the government.

Finally, if you drive to my office in an altered state of consciousness, such as intoxication with recreational drugs or alcohol, or are observably over-medicated with prescription medication, I reserve the option of contacting a family member, friend, or the authorities to arrange transportation and to ensure your safety and the safety of those whom you may encounter. This situation has also rarely occurred in my practice.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

CONSULATION WITH PRIMARY CARE PHYSICIAN AND/OR PSYCHIATRIST

Many times during the course of psychotherapy, I deem it helpful to consult with my clients' primary care physician and/or psychiatrist in order to best serve their health care needs; with some insurers (e.g., Medicare), this communication is *required*. This information will be limited to the minimum amount necessary to accomplish your best health care. Typically, before I contact your physician, I will discuss my impressions with you and the reasons I think it would be helpful to speak with him/her. If you have questions about this, we should discuss them at our next meeting. ***Your signature on this document serves as your agreement to this disclosure of Protected Health Information for the purpose of healthcare coordination. If you <u>REFUSE THE RELEASE OF THIS INFORMATION UNDER HIPPA</u>, please initial here _____. (If you refuse, it may make it impossible for us to serve you due to insurance regulations.) Your signature on this document, minus any initial on the line above, authorizes us to release information to your healthcare providers for the purpose of healthcare coordination.***

AGREEMENT AND SIGNATURES

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. You will be provided with a copy of this agreement if you so desire (please ask at your first appointment) and I will keep the original in your file at my office.

_____ _____

Client/Guardian Signature Date

_____

Relationship to Client (if client is a minor or unable to give legal consent)

_____

Client Printed Name

___ _____ _____

K. Spencer Wilson, Ph.D., OK HSP Psychologist Date
Kristin L. Wilson, M.A., Licensed Professional Counselor
Rachel Gurule, M.A., Licensed Professional Counselor
Keesha L. Kuntz, M.A., Licensed Professional Counselor
Krista Quigley, M.Ed., Licensed Professional Counselor
Stacy Lee, Ph.D., Under Supervision for Licensed HSP Psychologist
Intern:

_____ Initials

WILSON PSYCHOLOGICAL ASSOCIATES, PLLC
501 SE Johnstone, Suite 503
Bartlesville, Oklahoma 74003
(918) 337-6050 Fax (918) 337-6061

The following information is to be completed by a parent or guardian requesting services for the child/teenager. The information requested will be very helpful in understanding him/her. Feel free to add as much information as you think will be helpful in understanding the background/nature of the problem or your child. The highest standards of professional confidentiality are maintained, with the exceptions provided for by law and outlined in the treatment contract. All information, with the exception of those circumstances provided for by law, is kept strictly confidential and can only be released with parent/guardian written consent.

Name of child/teen: _____ Age: _____

Date: _____ Child/teen birthdate: _____ SSN: _____

Name of custodial parent: _____

Name of individual completing this form: _____

Relationship of individual completing form to child/teen: _____

Name of Biological Mother:_____ DOB:_____

Address:_____ City:_____ State:_____ Zip:_____

Telephone: Home_____ Work_____ Cell_____

Name of Biological Father:_____ DOB:_____

Address:_____ City:_____ State:_____ Zip:_____

Telephone: Home_____ Work_____ Cell_____

Name of Stepmother:_____ DOB:_____

Address:_____ City:_____ State:_____ Zip:_____

Telephone: Home_____ Work_____ Cell_____

Name of Stepfather:_____ DOB:_____

Address:_____ City:_____ State:_____ Zip:_____

Telephone: Home_____ Work_____ Cell_____

Emergency Contact Person (other than household member):

_____ Initials

Name_____ Address_____

Relationship_____ Telephone (H)_____ (W)_____

Name of Primary Care Physician: _____

Phone Number: _____

Last Physical Examination: _____

Medications Currently Taking (Names/Dosages):

_____

_____

_____

_____

Describe the problem(s) for which counseling or assessment services are being sought:_____

_____

_____

_____

_____

_____

How long ago did the above mentioned problem(s) begin? Have they persisted consistently since that time?

_____

_____

_____

_____

List all people now living in the household, then draw a line and list any others who have lived in the same household with the child in the child's lifetime.

_____ Initials

Name Relationship to child/teen Age Highest school grade Occupation

_____

_____

_____

_____

_____

_____

_____

A. Developmental Factors

1. Did the child/teen's mother have toxemia or eclampsia?

2. Was there Rh factor incompatibility?

3. Was the child/teen born on schedule?

4. What was the duration of labor?

5. Was the mother given any drugs to ease the pain of labor? If yes, which ones?

B. Postnatal Period & Infancy

6. Were there early feeding problems with your child? If yes, please explain.

7. Was your child colicky?

8. Were there early infancy sleep pattern difficulties? If yes, please explain.

9. Were there problems with your child's responsiveness (alertness) as an infant?

_____ Initials

10. Did your child experience any health problems during infancy?

11. Did your child have any congenital problems?

12. Was he/she an easy baby? By that I mean, did he/she cry a lot? Did he/she follow a schedule fairly well?

___Easy ___Average ___Difficult

13. How did he/she behave with other people?

___More social than average ___Average sociability
___More unsociable than average

14. When he/she wanted something, how insistent was he/she?

___Very insistent ___Average ___Not at all insistent

15. How would you rate his/her activity as an infant/toddler?

___Very active ___Average ___Not active

Age sat by self:_____ Age walked alone:_____ Age said first word: _____

Age talked in sentences: _____ Age gave up the bottle: _____ Age toilet trained: _____

C. MEDICAL HISTORY (If other than "Good," please explain)

16. How healthy is your child today? ___Good ___Fair ___Poor

17. How is his/her hearing? ___Good ___Fair ___Poor

18. How is his/her vision? ___Good ___Fair ___Poor

19. How is his/her gross motor coordination? ___Good ___Fair ___Poor

20. How is his/her fine motor coordination? ___Good ___Fair ___Poor

21. How is his/her speech articulation? ___Good ___Fair ___Poor

22. Does he/she have any problems sleeping? ____No ____ Yes

23. Is he/she a restless sleeper? ___No ___Yes ___Don't know

24. Does he/she have bladder control problems…

…at night ___No ___Yes If yes, how often
If yes, was he/she ever continent

…during the day ___No ___Yes If yes, how often
If yes, was he/she ever continent

25. Does he/she have bowel control problems…

…at night ___No ___Yes If yes, how often
If yes, was he/she ever continent

…during the day ___No ___Yes If yes, how often
If yes, was he/she ever continent

26. Does he/she have any appetite problems?

___Overeats ___Average ___Undereats

27. Has he/she had any accidents resulting in the following?

___Broken bones ___Severe bruises ___Lost teeth
___Severe lacerations ___Stomach pumped ___Sutures
___Head injury ___Eye injury ___Other:

28. How many accidents? ___One ___2 – 3 ___4 – 7 ___8 – 12 ___Over 12

29. Does your child have any problems pronouncing words or speaking? If yes, please explain.

30. Does your child have excessive awkwardness or clumsiness? If yes, please explain.

D. SCHOOL HISTORY

31. Please summarize your child's progress (e.g., academic progress, testing) within each of these grade levels (please note grade for each notation):

KINDERGARTEN:_____
_____
_____
_____
_____
_____

_____ Initials

GRADES 1 AND 2:_____

GRADES 3 AND 4:_____

GRADES 5 AND 6:_____

GRADES 7 THROUGH 12:_____

32. Has he/she ever been in any type of special educational program? How long?

___Learning disabilities class
___Behavioral/emotional disorders class
___Resource room
___Speech & language therapy
___Special tutor
___Other:

33. Any previous psychological testing? When? By Whom? (*Please have copies sent to the office as soon as possible so I may decide what additional testing may be needed*)

E. SOCIAL HISTORY

34. How does your child get along with siblings?

___No siblings
___Better than average
___Average

_____ Initials

___Worse than average

35. How easily does your child make friends?
___Easily
___Average
___Difficult

36. Does your child sustain friendships with other children? Yes No How long?

37. How well does your child get along with other children in the neighborhood?
___No other children
___Better than average
___Average
___Worse than average

38. How often is your child invited over to other children's homes?

39. With what age group does your child typically choose to play?
___Peers, same age
___Older children
___Younger children
___Don't know

40. When you observe your child playing with other children, is he/she usually the:
___Leader ___Follower ___Peer

41. What kinds of behavior from other children frustrate and/or anger your child?

42. How important is it for your child to control the play or make the rules when playing with other children?
___Very ___Somewhat ___Not much ___Don't know

43. What about your child's behavior most concerns you at present?

44. If, on ten occasions, you tell your child to do something (e.g., pick up his room, go to bed, etc.), how many times does he/she comply with your first request?

45. Of those ten directions, how many times will he/she eventually do what you request?

46. When he/she fails to comply with your request, how do you respond?

47.When he/she is engaging in a behavior that you want stopped (e.g., teasing his sister, running in the house, etc.), how do you respond?

48.When you want your child to do something, how do you try to get him/her to do it?

49.To what extent are you and your spouse consistent with disciplinary strategies?
___Most of the time ___Some of the time ___None of the time

50.Have any of the following stress events occurred within the past 12 months? (Please explain)

___Parents divorced/separated ___Family accident/illness
___Death in family ___Other:

51. Any problems in the **child's family** (e.g., parents, grandparents, aunts/uncles) with the following?

Problems with aggressiveness, defiance, and oppositional behavior as a child_____
_____
_____
_____
_____
_____

Problems with attention, activity, and impulse control as a child_____
_____
_____
_____
_____
_____

Learning disabilities_____
_____
_____
_____
_____
_____

Problems with depression, anxiety or thought disorders_____

_____

_____

_____

52. Describe any highly distressing or traumatic experiences your child/teen has experienced. Please include dates and events.

_____

_____

_____

_____

_____

_____

53. How has the child/teen dealt with those events?

_____

_____

_____

_____

54. Are you aware of any physical or sexual abuse your child/teen has experienced? If yes, please describe, including approximate dates of abuse and to whom the abuse has been reported.

_____

_____

_____

55. Has the child/teen experienced the death of anyone close to him/her? If yes, please describe.

_____

_____ Initials

56. Describe the child's/teen's religious experience; include details such as denomination, whether he/she is a member/regular attender of a church, religious training at home, prayer life, concept of God, etc.

57. Has your child ever received counseling or psychotherapy? YES NO If yes, please list names of providers, dates, and your perception of success or lack thereof.

Name of Provider	Date From/Date To	Successful?

58. How have your prepared your child/teen for his/her first appointment? Does he/she want to come?

_____ Initials

59. Please use the space below to add any further information you think would be helpful in understanding your child or the nature of his/her problem:

_____ Initials

Wilson Psychological Associates, PLLC
501 S Johnstone Avenue, Suite 503
Bartlesville, OK 74003
Phone (918) 337-6050 Fax (918)337-6061

Acknowledgement of Receipt of Notice of Mental Health Providers Policies and Privacy Practices and Client Rights Information (HIPPA Notice)

By signing this form below, I acknowledge that I have been offered and taken for my records (or, refused) a copy of Wilson Psychological Associates, PLLC's Privacy Policies and Practices (HIPPA Notice).

Please check the appropriate statement below.

_____ I received this notice.

_____ I have been offered and refused a copy of this notice.

_____
Patient Printed Name

_____ _____
Patient or Parent/Guardian Signature Date

_____ _____
Staff Signature/Witness Date

_____ Initials

INSURANCE/PAYMENT INFORMATION

Responsible Party
Last Name_____ First Name _____ M.I._____
Address_____
City_____ State_____ Zip_____ Home Phone (___)_____
Date of Birth_____ SSN_____ Relationship to Patient _____
Employer_____ Address_____
Occupation_____ Business Phone (___)_____
Spouse Name_____ Spouse's SSN_____

Primary Insurance Co_____ Effective Date_____
Insured's Name_____ DOB_____ SSN_____
Address (if different)_____
Policy No._____ Group No_____ Relationship to Patient _____

Secondary Insurance Co_____ Effective Date_____
Insured's Name_____ DOB_____ SSN_____
Address (if different)_____
Policy No._____ Group No_____ Relationship to Patient _____

I (we) authorize payment of medical benefits to the provider herein for all medical/psychological services rendered. I (we) authorize the provider or Wilson Psychological Associates to release any information required to process my insurance claims. I (we) authorize my insurance benefits to be paid directly to Wilson Psychological Associates. I (we) understand that I (we) am (are) financially responsible for payment of any insurance deductible, copayments, and non-covered charges or services. A photocopy of this signature is valid as the original.

Signature of Responsible Party_____ Date_____
Signature of Spouse_____ Date_____
(required if marital therapy)

Please provide us with your insurance card so that we may have a copy on file. Please notify us of any changes to your insurance. We reserve the right to require you to file your own insurance if we are not made aware of insurance changes within two visits of the policy change. Thank you for your consideration in this matter.

_____ Initials

Wilson Psychological Associates, PLLC
501 Southeast Johnstone Avenue, Suite 503
Bartlesville, Oklahoma 74003
Phone (918) 337-6050 Fax (918) 337-6061

Confidentiality and Witness Waiver for Minor Psychotherapy Clients

For children (persons under the age of eighteen), therapy needs to be a place of safety and trust. If a child or adolescent is afraid that something he/she may say privately in therapy will be communicated back to his/her parents, then the value of therapy is diminished. Children have the same right to confidentiality as do their parents. However, you as parents also have the right to make responsible choices regarding your child's welfare and treatment. Consequently, by your signature below you agree to the following terms regarding your child's treatment:

1) I, as your child's therapist, will keep all information shared with me by or about your child confidential, unless your child agrees it may be shared. You will turn over the right of privilege to your child regarding his/her clinical information.
2) I will assist your child in sharing with you directly information that I or he/she think needs to be shared.
3) I will give you regular updates as to the progress of your child's therapy.
4) At the conclusion of therapy, I will provide you with a written summary of your child's progress in therapy.
5) If you child poses a serious risk to either him/herself or someone else, I will non-consensually break confidentiality in order to protect the person in danger. We will discuss and clarify the nature of 'serious risk' prior to beginning therapy.
6) When a family is confronted by parental separation or divorce, it is very hard on everyone. It is particularly hard on children. When the parental relationship is unsafe, it is even more important that therapy presents a safe environment. That safety is particularly endangered where a child has to worry that what he/she says in therapy will be revealed in court and used against one of his/her parents. In order to protect that safety, I want us all to agree that the therapist will not be called as a witness by either party. Everyone needs to understand that a judge may not honor this agreement and that I may be required to be a witness, although I will try to prevent that from happening.

My signature below indicates my understanding and agreement to abide by these terms.

_____	_____
Client Printed Name	**Date**
_____	_____
Signature of Parent*	**Date**
_____	_____
Signature of Parent*	**Date**
_____	_____
Staff Signature/Witness	**Date**

(*Both parents must sign if there is any type of shared custody of the child; if not, documentation of the sole custody order must be provided.)

_____ Initials

Appointment Reminders and Online Appointment Scheduling

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) 2 days before your scheduled appointments.

You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit **www.wilsonpsychologicalassociates.com**, click on the provider's page you want to see, and click **schedule an appointment with (providers name)** to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have Internet access, you are sure to enjoy the convenience of this online system.

Please note: Cancellations within 24 hours of your scheduled appointment must be done by phone by calling the office at (918) 337-6050.

Your name: _____

Your email address: _____

Your cell phone number: _____

Your cell phone carrier (circle one):

Alltel AT&T Boost Mobile Nextel Sprint SunCom

T-mobile Verizon VoiceStream Virgin Mobile (Other) _____

Where would you like to receive appointment reminders? (check one)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ Via an automated telephone message to my home phone

_____ None of the above. I'll remember my appointments on my own.
(Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

---------- ----------

Signature Date

_____ Initials